

FILED APR 16 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14380

1747

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1747	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 40 yrs		c. CITY (If outside corporate limits, write RURAL and give township) 9 TOWN Kansas City		3098	
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital				d. STREET ADDRESS (If rural, give location) 214 South Askew			
3. NAME OF DECEASED (Type or Print) EDITH		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH		March 29, 1953		5. SEX F		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH April 5, 1880		9. AGE (in years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
11. BIRTHPLACE (City and State or Foreign Country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Samuel DeFrance		13b. MOTHER'S MAIDEN NAME Sara A. Thomas	
14. NAME OF HUSBAND OR WIFE James A. Mosbarger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Ione Mosbarger, 214 S. Askew, KC Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia (b) metastatic cancer (c) Primary cancer of cervix uteri II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. no hemorrhage no surgery				INTERVAL BETWEEN ONSET AND DEATH 24 hrs undetermined unknown 171X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 19, 1953 to Mar 29 1953 that I last saw the deceased alive on 3-28, 1953 and that death occurred at 5:18 A. M., from the causes and on the date stated above.							
23a. SIGNATURE J. L. Jones DO		23b. ADDRESS 3825 Virginia		23c. DATE SIGNED 3/29-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/31/53		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
DATE REC'D BY LOCAL REG. 3-30-53		REGISTRAR'S SIGNATURE S. Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & MCCLURE, Kansas City, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

J T Brownell

Licensed Embalmer No. *4904*

P. O. Address *17 C New*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.